INTAKE FORM

**Date Referral Received:**

# SOURCE OF INTAKE REQUEST

Name of referring person/agency: Phone:

# FAMILY INFORMATION

Child's name:

Male

Female\_

DOB / /

Child’s Address: Guardian:*(If other than parent)* Mother's name: Phone: (H) (W) Address: Father's name: Phone: (H) (W) Address: Directions to family's home:

Medical Diagnosis *:(If any)*

Family physician: Phone:

# CONCERNS OF REFERRAL SOURCE

**CONCERNS OF PARENTS**

**CURRENT SERVICES (check all that apply)**

\_\_\_ Child Care Services \_\_\_ Medicaid (aka CHIP in SD)

\_\_\_ Supplemental Nutrition Assistance Program (SNAP) *Children’s Health Insurance Program*

\_\_\_ Temporary Assistance to Needy Families (TANF) \_\_\_ Private Health Insurance

\_\_\_ Women, Infant, Children Nutrition (WIC) \_\_\_ Parenting Classes

\_\_\_ Energy Assistance & Weatherization Program \_\_\_ Respite Care

\_\_\_ Head Start/Early Head Start \_\_\_ Housing Assistance

\_\_\_ Shriners \_\_\_ Family Support Program

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_